VS. A15ME(5) 5M 9/55

| M    | ARYLAND S | TATE D | EPARTMEI | NT OF | HEALTH- | -BAL | TIMORE, |
|------|-----------|--------|----------|-------|---------|------|---------|
| 9184 | MEDICAL   | EXA    | MINER'S  | CERT  | IFICATE | OF   | DEATH   |

()9155 Reg. Dist. No.

18

| I. PLACE OF DEATH o. COUNTY Howay                            | vi  |                        | MARYLAND          | 2. USUAL RESIDENCE  o. STATE Warylan                     |  | ed. If Institu            | Υ          | lence be       |        | ssion)             |
|--|---|------------------------|-------------------|--|--|---------------------------|------------|----------------|--------|--------------------|
|  | (If outside corporate fimits, write   | RURAL C. LENG          | TH OF STAY IN 16  | c. CITY OR TOWN  | (If outside corporate  | limits, write             |            |                |        | wn)                |
|  | tal or institution (ii  | Fnot in hospital, give | street address)   | d. STREET ADDRESS' Box 301                               |  |                           |            |                | ON     | A FARM?            |
| 3. NAME OF<br>DECEASED<br>(Type or print)                    | MA TTTE   | CRADDO                 | Middle            | Last   | 4. DATE<br>OF<br>DEATH   | Mont                      |            | 0oy            |        | ear<br>9           |
| 5. SEX Female  | 6. COLOR OR RACE  |                        |                   | March 28.18  | los  | GE (In years<br>birthday) | IF UNDER   |                |        | ER 24 HRS.<br>Min. |
| 10a. USUAL OCCUPA  | TION (Give kind of work d<br>king life, even if retired)  | None                   | USINESS OR INDUST | RY 11. BIRTHPLACE (Stat                                  | te or foreign country  Caroline                                  | ***                       | 12. CIT    | IZEN O         | F WHAT | COUNTRY            |
| 15. WAS DECEASED (Yes, no, or unknown)                       | EYER IN U. S. ARMED FOR<br>(If yes, give wer or dates of a  |                        |                   | Sophia<br>Formant<br>Prov Craddoc                        | ek Tauna)  | Address                   |            |                |        |                    |
| Conditions, if gove rise to imm (o), stoting the couse lost. | rediote cause   | Hypertens              |                   | ılar Disease   |  | NDITION GIV               | /EN IN PAI | 3<br>RT 1(o) 1 | PERFO  | AUTOPSY<br>PRMED?  |
| PART II. O   | AUSE WAS ONTRIBUTING   20th   | DESCRIBE HOW IN        | JURY OCCURRED. (E | nter noture of injury in Po                              | ort I or Port II of ite  | m 18.}                    |            |                | YES 🗌  | ио □               |
| 20c. TIME OF INJ   | 1.  |                        | t while facto     | CE OF INJURY (Home, for<br>ory, street, office bldg., et | rm, 20f. (City or to   | wn)                       | {Co        | ounty)         |        | (Stote)            |
| ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)             | that I tack charge and from: Natural of the state of the | causes (T), Acc        | ident [], Sui     | M.D. CHIEF MEDICAL I ASSISTANT MEDI DEPUTY MEDICAL       | EXAMINER CAL EXAMINER CAL EXAMINER CAL EXAMINER CAL EXAMINER CAL | ctian 🚺,<br>ermined c     | Aug.       | j.<br>15,1     | DATE S | SIGNED             |
| REMOVAL (Special Burial                                      | 8-19-59   | Ве                     | e of cemetery or  |  | 22d. LOCATION Belhave  | n.N.C.                    |            |                | (Stot  | o)                 |
| 23. FUNERAL DIRECTO  | or's signature<br>nbothom, Elli   | Lcott City             |                   |  | AUG 1 8 '59  | 24b. REGI                 | STRAR'S SI |                |        |                    |

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| ELUCI MILLO CAL CAMINER: Into Certificate should be executed within 24 hours direct depth. If any delay is pressory, please a | e the cer. To, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral direct. Page 4 should | ,      | JNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registror priar to burial, cremati |
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|    | MA | RYLAND | STATE | DEPARTME | NT OF | HEALTH- | -BALTIMORE | , 18 |
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09156

Reg, Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. COUNTY O. STATE b. COUNTY MARYLAND C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? 109 Whiskey Bottom Road YES NO NAME OF Middle DATE Year Month Day DECEASED (Type or print) DEATH 284012 19 59 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 1 8. DATE OF BIRTH 9. AGE |In years IF UNDER TYEAR IF UNDER 24 HRS. last birthday) Months WIDOWED | DIVORCED | Feb. 7. 1891 68 YES. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Laborer Baltimore County, Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Jacob Edler Mary C. Arnold 16. SOCIAL SECURITY NO. 17. INFORMANT Address Yes World War None 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: HEMORRARALE IMMEDIATE CAUSE (a) **DUE TO** Canditians, if any, which gave rise to immediate cause DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? NONE NO 🖸 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, form, 20d. INJURY OCCURRED 20f. (City or town) (County) (State) factory, street, affice bldg., etc.) D. m. at wark at wark p. m. 21. I certify that I took charge of the remains described above, held on Autopsy [], Inspection K. Inquiry , and find that deoth resulted from: Notural causes D. Accident , Suicide . Homicide . Undetermined couse DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland Burial Baltimore National Cemetery 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24b. REGISTRAR'S SIGNATURE 240. REC'D BY REGISTRAR AUG 1 2 '59 arthur S. Krous

VS. A15ME(5) SM 9/55

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|--|--|-----------------|---|------------------------|---------------|----------------|------------------------------------|-------------|----------|----------|----------------|
| 1. PLACE OF DEATH  |  |                 | MARYLAND                                | 2. USUAL RESID         | ENCE (Whe     | are deceased   | lived. If institution b. COUNTY    | nı Residenc | e before | odmissio | on)            |
| Howard   |  |                 | MARTLAND                                | Mary                   | and           |                |                                    | F           | Towa :   | rd       |                |
| b. CITY OR TOWN<br>RURAL and give  | (If autside corporate lim<br>nearest tawn)           | its, write c.   | LENGTH OF STAY IN 16                    | c. CITY OR T           | OWN (If au    | tside carpore  | ite limits, write RI               |             |          |          |                |
| Ellicot  | t City   |                 |   | X Ell                  | icott         | City           |                                    |             |          |          |                |
| OR INSTITUTION   | PITAL (If not in haspital,                           | give street add | lress)                                  | d. STREET A            |               |                |                                    |             |          | IS RESI  | DENCE<br>FARM? |
| 268  | Main St.   |                 |   | 268                    | Main          | St.            |                                    |             |          | YES 🗌    | NO 🔣           |
| 3. NAME OF<br>DECEASED   |  | rst             | Middle                                  | Last                   |               | 4. DATE<br>OF  | Mant                               |             | Doy      | Y        | 'ear           |
| (Type or print)  | MELISS!  |                 |   | GLOVER                 |               | DEATH          | Aug. 16                            |             |          |          | 9              |
| 5. SEX   | 6. COLOR OR RACE                                     | 7. MARRIED      | NEVER MARRIED                           | B. DATE OF BIRTH       | 1             | 9              | O. AGE (In years<br>lost birthday) | IF UNDER    |          |          |                |
| Female   | Colored  | WIDOWED         | DIVORCED [                              | 3-14-189               | 95            |                | 64 yrs.                            | Manths      | Days     | Haurs    | Min.           |
| Oa. USUAL OCCUPAT  | ION (Give kind of work arking life, even if retired  | dane 10b. KIN   | D OF BUSINESS OR IND                    | USTRY 11. BIRTHPL      | ACE (State of | ar foreign cou | intry)                             | 12. CITI    | ZEN OF   | WHAT     | COUNTRY        |
| At Home  |  |                 |   | South                  | Caro          | Idna           |                                    |             |          |          |                |
| 3. FATHER'S NAME   | 40   | W = b           |   | 14. MOTHER'S           |               |                |                                    |             |          |          | /-             |
| Walte  | r Quarterba  | um              |   |                        | Unkn          | COM            |                                    |             |          |          |                |
| 5. WAS DECEASED EV   | ER IN U. S. ARMED FO                                 | RCES? 16. SO    | CIAL SECURITY NO. 17.                   | INFORMANT              | Viana         | W              | Addr                               | ess         |          |          |                |
| No No  | (If yes, give wor or dates of                        | service]        |   | ames Glov              | ttt war       | abl and        | 264                                |             |          |          |                |
|  | EATH [Enter only one c                               | guse per line f |   | CUIDS GIO              | GL PUT        | Surrano        | 9.00.1                             |             | INTER    | RVAL BET | WEEN           |
|  | ATH WAS CAUSED BY:                                   |                 | 1                                       | ://                    |               |                |                                    |             | ONSE     | TAND     | DEATH          |
| 0.0  | IMMEDIATE CAUSE (                                    | 0)              | deac fra                                | mure                   |               |                |                                    |             | 12       | w        | epe            |
| 422.1  | DUE TO   | )               |   |                        |               |                |                                    |             |          |          |                |
| Conditions, if   |  | b)              |   |                        |               |                |                                    |             |          |          |                |
| gove rise ta<br>catse (o), stating   |  | nt              | 1 1                                     | -11                    | 11            | 1              | 77.                                |             | > 11     | /        |                |
| lying couse lost   |  | delle           | isselerouc                              | Cardis-                | Cas.          | eula           | V Lles                             | walls       | 17       | 1        | in             |
| PART II. O   | THER SIGNIFICANT CON                                 | NDITIONS CON    | TRIBUTING TO DEATH BL                   | T NOT RELATED TO       | THE TERMIN    | NAL DISEASE    | CONDITION GIVE                     | EN IN PART  | 1(0) 19  |          |                |
| PART 11, O  PART 11, O  200. ACCIDENT W  OR CONTRIBUTION (IF EITHER, NOTIF |  | 1               | Tone                                    |                        |               |                |                                    |             |          | PERFOR   | NO NO          |
| 200. ACCIDENT W  | VAS UNDERLYING                                       | 20b. DESCRI     | BE HOW INJURY OCCURR                    | ED. (Enter nature a    | injury in P   | art I ar Port  | 11 of item 1B.1                    |             |          | 140      | 110/23         |
| OR CONTRIBUTIN   | VAS UNDERLYING  G CAUSE OF DEATH Y MEDICAL EXAMINER) |                 |   |                        | 1             |                |                                    |             |          |          |                |
|  |  | or 204 INTU     | RY OCCURRED 20e. F                      | PLACE OF INJURY II     | tome form     | . 20f (Cib.    | or town)                           | 10          |          |          | 164-4-1        |
| 20c. TIME OF INJU  |  | While           | _ Not while f                           | octory, street, office | bldg., etc.)  | Laur. (City o  | n lownj                            | (C          | ounty)   |          | (State)        |
| p. m.  | . 19   | at wark         | at work                                 |                        |               |                |                                    |             |          | 100      | 4              |
| 21. I certify t  | that I attended the                                  | deceased        | from Ott 10                             | 195                    | , to au       | quat 1         | 6,1959                             | that I I    | ast say  | w the    | decease        |
| alive order  | west 15  | 19.5            | 10                                      | h occurred at          |               |                |                                    |             |          |          |                |
| 1  | Cell me  |                 | , | A                      |               |                | et, city ar towp,                  |             | ic dure  | DA       | TE SIGNE       |
| ACTUAL   | filkant 1  | ama             | MIGH                                    | 91 /2 e                | att F         | it             | mida                               |             | Peri     | 11.      | - 50           |
| SIGNATURE  | commy, p.  |                 | 1                                       | M.D. C.                |               | -              | ,,,,,,                             |             | 1        | . 10     |                |
| PHYSICIAN'S  | W1774  |                 | 0                                       | 72774                  |               | 7d A 36        |                                    |             | (/       |          |                |
|  | William F.G  |                 |   |                        |               | City, M        |                                    |             |          |          |                |
| _ REMOVAL (Specif  | ON, 22b. DATE THERE                                  |                 | 2c. NAME OF CEMETERY                    |                        |               |                | ON (City, town, a                  |             |          | (State)  | )              |
| Burial   | 8-21 -59   |                 | St. Watt                                | hews                   |               | St.            | Matthews                           | S.C.        | ,        |          |                |
| 3. FUNERAL DIRECTO   | R'S SIGNATURE  |                 | ADDRESS                                 |                        | 24a. REC'D    | BY REGISTR     | AR 24b. REGIS                      | TRAR'S SIG  | NATURE   |          | 7377           |
| TO Minds   | hothom F114  | ant+ 0          | 14m 16d                                 |                        | DATRIC        | 1 8 '59        | (1-7%                              | 0 9 4       |          |          |                |

may be retain.

The haspital or attending physician.

FUNERAL DIX. TOR: After this certificate has been signed by the attending physician and campletely filled in by A. funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, crematian, ar remaval, and in any event within 72 hours after death. ITENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs TO HOSPITAL OF may be retain.

death. Page 4

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VS A15 (4) 15M 9/55

| Sulface and Sec. |                         | CERTIFIC   | ,             |          |
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VS A15 (4) 1SM 10/57

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|      | as been signed by the attending physician and campletely filled in by a funeral director. | ial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with |   |
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 9187 **CERTIFICATE OF DEATH** 

09158

Reg. Dist. No.

| 1. PLACE OF DEATH a. COUNTY   | Howard                                 | MARYLANI                                     | a. STATE  | here deceased lived. If inst    |  | fore admission)                                 |
|---|--|--|---|---------------------------------|--|---|
| b. CITY OR TOWN ( RURAL and give n  | If outside corporate limits, wri       | c. LENGTH OF STAY IN 1                       | c. CITY OR TOWN (IF   | outside corporate limits, wri   | te RURAL ond give n  | earest town)                                    |
|   | Ellicott                               | - F - U                                      | Dundalk   |                                 | 03-5   | 3_2   |
| d. NAME OF HOSPI  | TAL (If not in hospital, give str      |  | d. STREET ADDRESS   | 1100                            |  | IS RESIDENCE     ON A FARM?                     |
|   | Schaefers Con                          | nval. Home                                   | 6805 Duluth   | Avenue #22                      |  | YES NO  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | CALVIN                                 | Middle TURNER                                | GRIER. SR.  | 4. DATE<br>OF<br>DEATH Augus    |  | 19 59   |
| S. SEX  |  | ARRIED NEVER MARRIED                         |   | 9. AGE (In ve                   | ors IF UNDER 1 YEA   | AR IF UNDER 24 HRS.                             |
| Male  | White WIDO                             | DIVORCED [                                   | Dec. 10, 189  | lost birthdo                    | yrs. Months Doys   | Hours Min.                                      |
| 100. USUAL OCCUPATION during most of wor Retired Ma 13. FATHER'S NAME                                   | king life, even if refired)            | ob. KIND OF BUSINESS OR IN<br>ethlehem Steel | DUSTRY 11. BIRTHPLACE (STOTE  Salisbury  14. MOTHER'S MAIDEN I                                      | y, Maryland                     | 12. CITIZEN  | OF WHAT COUNTRY?                                |
| Frederick   | A. Grier                               |  | Marguerite  | Febrenhach                      |  |   |
|   | R IN U. S. ARMED FORCES?               | 16. SOCIAL SECURITY NO. 17                   | . INFORMANT   |                                 | Address  | City  |
| No  | (II yes, give war as adias or service) | 217-10-3627 N                                | Ir. Calvin Grie   | er-Rt. 1. Mon                   | tgomery R  |   |
| PART I. DEA  / 53.9  Conditions, if o gove rise ta i cause (a), stating lying couse last.  PART II. OTI | mmediate the under: DUE TO (c)         | CANCER (                                     | TORY AND ENTERNA COM ATOSI  OF BOW E  SUT NOT RELATED TO THE TERM  RRED. (Enter noture of injury in | INAL DISEASE CONDITION          | GIVEN IN PART 1(o)   | S YR S  19. WAS AUTOPSY PERFORMED?  YES NO DE   |
|   | MEDICAL EXAMINER)                      |  |   |                                 | 5.711  |   |
| Y 20c. TIME OF INJUR<br>Hour o. m.<br>p. m.   | W W                                    |  | PLACE OF INJURY (Home, form foctory, street, office bldg., etc.                                     | n, 20f. (City or town)          | (County  | r) (Stole)                                      |
| 21. I certify the alive on S  |  | ased from \$ -\0                             | oth occurred at 2 45  |                                 | es and an the d  | saw the deceased ate stated above.  DATE SIGNED |
| PHYSICIAN'S<br>NAME (Type)  | PETER V                                | THORPE MY                                    | 2 21  | -10077                          | EITY   | 9-11-50   |
| REMOVAL (Specify)   | N, 22b. DATE THEREOF                   | 22c. NAME OF CEMETERY                        | or CREMATORY  | 22d. LOCATION (City, to         | The Real Property and the Street of the Stre | (Stote)   |
| Burial  23, FUNERAL DIRECTOR  | S SIGNATURE T                          | ADDRESS                                      | 24a. REC'   | Elkridge, D BY REGISTRAR 24b. R | EGISTRAR'S SIGNATI   | URE   |

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| DUDGIT/CHIAN    |  |                            |                          |                     |        |
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| Section 1       |  |                            |                          |                     | 465    |
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|                 | Or Annual  |                            |                          | 151/51/4            |        |
|                 |  |                            |                          |                     |        |
|                 | THE YEAR   |                            | 74 1 13 V 5 9 3 V        | N 509-21 1          |        |
| 450             |  |                            |                          |                     |        |
|                 |  |                            |                          |                     |        |
|                 |  |                            |                          | Partial territories |        |
|                 |  |                            |                          |                     |        |
|                 | and confirm in   |                            |                          | Partial territories |        |

M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09159

|   |               | 9188 CERTIFICATE OF   | DEATH   | Reg. Dist. No.   |
|---|---------------|---|---|--|
| ) |               | PLACE OF DEATH  G. COUNTY  HOWARM  2. USUAL RES  G. STATE   | SIDENCE (Where deceased lived. If inst<br>handowed b. COU |  |
|   |               | b. CITY OR TOWN (If autside carporate limits, write RURAL and give recover town)              | TOWN (Koutside carporate limits, wri                      | ite RURAL and give nearest town)                             |
| ( |               | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  d. STREET   | ADDRESS Reposible Ru                                      | e. IS RESIDENCE<br>ON A FARM?<br>YES 2 NO                    |
|   |               | NAME OF DECEASED (Type or print) Joseph Danis / Harding   | ost 4. DATE OF DEATH AC                                   | Manth Day Year 11 1954                                       |
|   |               | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIR  | 22/87/ last birthde                                       | pars IF UNDER 1 YEAR IF UNDER 24 HRS  Manths Days Haurs Min. |
|   | 100           | Do. USUAL OCCUPATION Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHE Service Flavor Have  | PLACE (State or foreign country)                          | 12. CITIZEN OF WHAT COUNTR                                   |
|   | 13.           | Basill W. Harding   | Latha   | Owens  |
| - |               | S. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Yes, no fet spikinown)  (If yes, give wor or dates of service)  (If yes, give wor or dates of service) | Harding, I  | autu/Md  |
|   |               | 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  PART 2. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)         | cinoma tosis  | INTERVAL BETWEEN ONSET AND DEATH                             |
|   |               | Canditions, if any, which) (b) Cancer of Skin   |   | 14 4 aan   |
|   |               | gave rise to immediate case (a), stating the <u>under-lying cause last.</u> DUE TO  (c)   |   |  |
| 0 | CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED T   | O THETERMINAL DISEASE CONDITION                           | GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 12      |
|   |               |   | of injury in Part I ar Part II of item 1B.                |  |
|   | MEDICAL       | 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 40e. PLACE OF INJURY Haur a. m. 19 While Not while at wark at wark 4 ot wark 4  | (Hame, farm, 20f. (City or tawn) ice bldg., etc.)         | (Caunty) (State)   |
|   |               | 21. I certify that I attended the deceased from 24, 193 alive on 44, 11 193 9, and that death occurred a  | 1. to Aug 11 , 19   | 1. that I last saw the deceases and on the date stated above |
|   |               | ACTUAL Robert I My Comes M.D.   | ADDRESS (Street, city or to                               | own, state) DATE SIGNI                                       |
| 1 |               | PHYSICIAN'S ROBERT S. McCENEY   | 402 MAIN ST.  | Al care  |
|   | 220           | 20. BURIAL, CREMATION, 226 DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify)  | 22d. LOCATION (City, too                                  | wn, ar county) (State)                                       |
| 1 | 23.           | S. FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS MILL Mangledon, Lacrel Med  |   | REGISTRAR'S SIGNATURE  |

TO HOSPITAL OR TO FUNERAL DE VS A15 (4) 15M 9/55

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or removal.

VS. A15ME(5) 5M 9/55

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| 8        | A  |   |
| emation, | M  | j |
| 5        | _  | / |

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 9189 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09160 Reg. Dist. No.

| 1. PLACE OF DEATH O. COUNTY Howard MARYLAND         |                                   |              |                                | 1 0          | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  o. STATE  b. COUNTY |                  |                      |              |                                     |
|---|-----------------------------------|--------------|--------------------------------|--------------|--|------------------|----------------------|--------------|-------------------------------------|
|   | 4 - 4 74 4 12 14                  |              |                                |              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                           |                  |                      |              |                                     |
| b. CITY OR TOWN I<br>and give nearest tow<br>Savage | r ourside corpordie limits,<br>n) | Write RURAL  | c. LENGTH OF STAY IN           | X            | Jessups  | (If outside cor  | porote limits, write | RURAL ond    | give neorest town)                  |
|   | AL OR INSTITUTION                 | N (If not in | hospital, give street address) | d            | STREET ADDRESS   |                  |                      |              | e. IS RESIDEN                       |
| Arundel G   |                                   |              | an Road                        | 1            | Box 151 A  | Rt 1             |                      |              | ON A FAR                            |
| 3. NAME OF DECEASED                                 |                                   | First        | Middle                         | 3.10 (1)     | Lost   | 4. DATE          | Mont                 | h            | Day Year                            |
| (Type or print)                                     |                                   | D.           | HUNLEY                         |              |  | DEATH            | August               | 28           | 19 4                                |
| 5. SEX 6. COLOR OR RACE 7                           |                                   | CE 7. MAI    |                                |              | DATE OF SIRTH  |                  | 9. AGE (In years IF  | IF UNDER 1   | YEAR IF UNDER 24 I                  |
| Male  | White                             | WIDOV        | WED DIVORCED                   | Jul          | v 19.1924  | 4                | 35 yrs.              | Months D     | lays Haurs Min.                     |
| 10a. USUAL OCCUPATI<br>during most of worki         | ON (Give kind of wo               | ork done 10t | . KIND OF BUSINESS OR IN       | DUSTRY 11    | BIRTHPLACE (Stot   | le or fareign o  | country)             | 12. CITIZ    | EN OF WHAT COUN                     |
| Laborer   | ig ilie, even it renire           | raj          |                                |              | Tenn.  |                  |                      |              |                                     |
| 13. FATHER'S NAME                                   |                                   |              |                                | 14. A        | OTHER'S MAIDEN   | NAME             |                      |              |                                     |
| A (2 99   |                                   |              |                                | 1            |  | Bailey           | C.S. 14.54           |              |                                     |
| 15. WAS DECEASED EV                                 | inley                             | FORCES I     | 16. SOCIAL SECURITY NO. 1      | 17. INFORM   |  | DETTE            |                      |              |                                     |
| (Yes, no. or unknown)                               | Ilf yes, give wor or date         |              | 16. SOCIAL SECURITY NO.        | I/. INFORM   | ANI ·  |                  | Address              |              |                                     |
| Tes   | WW 2                              |              | 414-20-5715                    | James        | Hunley, I  | aurel            | Rt. L                | Md           |                                     |
| 18. CAUSE OF DEA                                    | TH [Enter only one                | cause per li | ne for (a); (b), and (c); ] "  |              |  |                  |                      |              | INTERVAL BETWEEN<br>ONSET AND DEATH |
| PART I. DEA   | TH WAS CAUSED BY                  | 11           | rushed Skull                   |              |  |                  |                      |              |                                     |
| 820   | IMMEDIATE CAUSE                   |              | Manea Skull                    |              |  |                  |                      |              | Instant                             |
| 0 30  | X DUE                             | 10           |                                |              |  |                  |                      |              |                                     |
| Conditions, if a                                    |                                   | (b)          |                                |              |  |                  |                      |              |                                     |
| (o), stoting the                                    |                                   | го           |                                |              |  |                  |                      |              |                                     |
| couse lost.   |                                   | (c)          |                                |              |  |                  |                      |              |                                     |
| Z PART II. OT                                       | HER SIGNIFICANT CO                | ONDITIONS    | CONTRIBUTING TO DEATH B        | BUT NOT RE   | ATED TO THE TERM   | MINAL DISEAS     | E CONDITION GIV      | EN IN PART   | 1(o) 19. WAS AUTOP                  |
| VIII VIII VIII VIII VIII VIII VIII VII              |                                   |              |                                |              |  |                  |                      |              | PERFORMED                           |
| 200 EXTERNAL CA                                     | ICE WAS                           | John DECCE   | DIRE HOW INDURY OCCURS         | D /5-1       |  |                  | A.1                  |              | YES NO                              |
| PART II. OT   | NTRIBUTING [                      | 200. 0630    | RIBE HOW INJURY OCCURRE        | D: (Chier no | ture of injury in Po   | art I or Part II | at item 18.)         |              |                                     |
|   |                                   | Dual         | rear wheels c                  | of dum       | p truck  | passed           | over hes             | d            |                                     |
| 20c. TIME OF INJU                                   | RY Month, Day,                    |              | d. INJURY OCCURRED 20e.        | PLACE OF     | NJURY (Home, far   | m, 20f. (City    | or town)             | (Coun        | ty) (Sto                            |
| 4.30 p.m.   | 8-28-59                           |              | work X of work                 | ravel        |  | -                | vage Ho              | ward         | Md                                  |
| 444   |                                   |              | remains described              |              |  |                  |                      |              | 200                                 |
|   |                                   |              |                                |              | _  |                  | nspectian 📆          |              | X, and find                         |
| death resulted                                      | from: Nature                      | al causes    | Accident ,                     | Suicide      | , Homicid  | le 🔲, Ui         | ndetermined o        | cause        |                                     |
|   | 47                                | 1            | DAX L                          | /            |  |                  |                      |              |                                     |
| ACTUAL<br>SIGNATURE                                 | 1101111                           | PC           | 18 less is Tors                | M.D.         | CHIEF MEDICAL E  | EXAMINER         |                      |              | DATE SIGNED                         |
| STOTION STOTIONS                                    | - W                               | w            | Jany wy                        | M.U.         | ASSISTANT MEDIC  | CAL FXAMINE      | P.                   | , , , ,      | ·                                   |
| EXAMINER'S  | 6 -                               |              | - TE D                         |              |  |                  |                      | 0_2          | 8-59                                |
|   | eorge E.B                         |              |                                |              | DEPUTY MEDICAL   |                  |                      |              |                                     |
| 220. BURIAL, CREMATIC<br>REMOVAL (Specify)          | N, ZZB. DATE THE                  | CEOF         | 22c. NAME OF CEMETERY          |              | TORY   |                  | TION (City, town,    |              | (Stote)                             |
| Burial  | 9.1.                              | 59           | Meadowridge                    | 3            |  | E                | lkridge,             | (d           |                                     |
| 23. FUNERAL DIRECTOR                                | 'S SIGNATURE                      |              | ADDRESS                        | 17011        |  | D BY REGIST      |                      | STRAR'S SIGN |                                     |
| TO O Ministration                                   | othom, Ell                        | icotte       | City. Md                       |              | DATERS   | JG 3 1 '5        | 9 ar                 | thun S. A    | Gans                                |

|                  |               | CAN SERVED TO THE |  |                        | TO BOOK AS AND AS A SECOND TO SECOND |
|------------------|---------------|-------------------|--|------------------------|--|
|                  |               | Annafyrans,       |  | The State of the Local | 77.01901   |
|                  |               | Jenseys           |  |                        |  |
|                  |               | A SHARE SHEET, MY |  |                        |  |
|                  |               | ON LES A B        | Baoff 4                                    | nered this deven       | and defineral  |
| 28 11 5          | DECINE IN     |                   | ZALIMEN CO                                 |                        |  |
|                  | 36.           | 122.07.45         |  | SELIU SELIU            | ally)  |
|                  |               | Tenns -           |  |                        | 27045  |
|                  | 7,5           | Light should      |  | 100                    | m4.0.4   |
| lat.             | Z .23 D       | rand, wainst u    |  | EX I                   | myT.   |
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| _ dosfedt        |               |                   | Litualia Station                           |                        |  |
| dasted           |               |                   |  |                        |  |
| dos/act          |               |                   |  |                        |  |
| drafast          |               |                   |  |                        |  |
|                  |               |                   | I puis bener                               |                        |  |
|                  |               |                   | I puis bener                               |                        |  |
| do Pari          | hied tryo be  | sear short pee    | I (I tolis iberies                         |                        |  |
| in in the second | head two for  | eesq shared       | Litela bener<br>d. Lo afecde que           |                        |  |
| M ine            | nded true for | trank pass        | Litela bener<br>d. Lo afecde que           |                        |  |
| in the tree      | hand true for |                   | Litela bener<br>d. Lo afecde que           |                        |  |
| M ine            | need two for  | Se sq shared      | Litala bener<br>di No alfebria que<br>gran |                        |  |
| St. And Are      | need two for  |                   | Litela bener<br>di la alectiva qua         |                        |  |

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|           | i h. |

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9190 CERTIFICATE OF DEATH

**CERTIFICATE OF DEATH** 

Reg. Dist. No.

09161

| 1. PLACE OF DEATH o. COUNTY Howard                                  |  | MARYLAND  | Maryland Howard   |                              |   |   |  |  |
|---|--|---|---|------------------------------|---|---|--|--|
| b. CITY OR TOWN ( RURAL ond give n  Ellicott                        |  | c. LENGTH OF STAY IN 1b   | c. CITY OR TOWN (III                                      | foutside corporate limits, v | write RURAL and give ne                   | arest town)                               |  |  |
| d. NAME OF HOSPI<br>OR INSTITUTION                                  | TAL (If not in hospital, give streeterick Road                           |   | d. STREET ADDRESS   | erick Road                   |   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO   |  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)                           | First GLE  | Middle  | Lost  | 4. DATE<br>OF<br>DEATH       | Month Do                                  | 9 19                                      |  |  |
| 5. SEX Male   |  | ARRIED NEVER MARRIED DIVORCED DIVORCED  | B. DATE OF BIRTH  | 9. AGE (In lost birth        | yeors IF UNDER 1 YEAR<br>doy) Months Doys | Hours Min.                                |  |  |
| 100. USUAL OCCUPATE during most of wor Boarding 13. FATHER'S NAME   | king life, even if retired)  | 0b. KIND OF BUSINESS OR INDU  | Middlet  14. MOTHER'S MAIDEN                              | own, Md                      | 12. CITIZEN O                             | F WHAT COUNTRY?                           |  |  |
|   | Refauver R IN U. S. ARMED FORCES? (If yes, give war or dates of service) |   | nformant ?  | war Flliaatt                 | Address *                                 | N Fig.                                    |  |  |
| 20g. ACCIDENT W.  | m mediate the under DUE TO (c) 14  | My early occurred to the state of the state | ortens &  | More                         | 2   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO 2 |  |  |
| 20c. TIME OF INJUI<br>Hour o. m.<br>p. m.                           | RY Month, Doy, Year 20c  | 1 6-  | ACE OF INJURY (Home, fo<br>ctory, street, office bldg., e | etc.)                        | (County)                                  |   |  |  |
| 21. I certify the alive an actual signature Physician's NAME (Type) | nat I attended the dece  |   | , 1930, to  |                              |   |   |  |  |
| 220. BURIAL, CREMATIC<br>REMOVAL (Specify<br>Burial                 | 22b. DATE THEREOF  | 22c. NAME OF CEMETERY C   | OR CREMATORY  | 22d. LOCATION (City,         |   | (Stote)                                   |  |  |
| 23. FUNERAL DIRECTOR  |  | ADDRESS   |   |                              | REGISTRAR'S SIGNATU                       | PRE                                       |  |  |

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Special Control of the Control of the

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| oleose exe   | shauld by   |                          | cremation   |
|--|---|--------------------------|---|
| scessory,  | Poge 4  |                          | to burial,  |
| TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours ofter death. If any delay is pacessary, please exe | cute the cert ite, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral direct Poge 4 shauld by | retoined for your files. | TO FUNERAL DIRECTOR: Page 3 shauld be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation |
| within 24 haurs ofter  | Give Pages 1, 2, an   | M3. Poge 5 may be        | nit. File pages 1 and   |
| old be executed  | encil in Item 18.   | ang with form P          | urial-tronsit perm  |
| uis certificate sha  | d "pending" in p  | miner's Office al        | d be used as a b  |
| L EXAMINER: TH   | writing the ward  | hief Medical Exa         | OR: Page 3 shaul  |
| DEPUTY MEDICAL   | tote the cer-   | orwarded to The C        | FUNERAL DIRECTO   |
| 10   |   | _                        | 2   |

VS. A15ME(5) 5M 9/55

| . •                   | LACE OF DEATH   | Howard   |   | MARYLAN  | 2. USUAL RESIDENCE (  o. STATE Mar   | Where deceased li<br>yland   | ved. If Institu                             |                             |                                  | ission)                             |
|-----------------------|---|--|---|--|--|--|---|-----------------------------|----------------------------------|-------------------------------------|
| b.                    | and give nearest low  |  | e RURAL   | c. LENGTH OF STAY IN 18  |  |  | e limits, write                             | RURAL and give              | nearest to                       | wn)                                 |
| d                     | ETTTC   | ott City   | If not in hors  | pital, give street oddress)  | d. STREET ADDRESS  | t City   |   |                             | le IC P                          | ESIDENCE                            |
|                       |   | ells Avenue  | ii noi iii noij   | prior, give siteer occitessy   | /  | s Avenue   |   |                             | ON                               | A FARM?                             |
| ·D                    | IAME OF<br>DECEASED<br>Type or print)   | Fir<br>Rona  | _   | Middle<br>S  | losi<br>Myers  | 4. DATE<br>OF<br>DEATH   | Month<br>8                                  | h De                        |                                  | rear<br>1959                        |
| 5. SE                 | Male  | 6. COLOR OR RACE Colored   | 7. MARRIE   | D NEVER MARRIED TO   | 8. DATE OF BIRTH 9-28-1954   | 9. A   | GE (In years st birthday)                   | Months Days                 | R IF UND                         | Min.                                |
| 10a.                  |   | ON (Give kind of working life, even if retired)  | done 10b. K   | IND OF BUSINESS OR INDU  |  |  | γ)  | 12. CITIZEN                 | OF WHAT                          | COUNTRY                             |
| 13. 1                 | NONE<br>FATHER'S NAME   |  |   | None   | 14. MOTHER'S MAIDEN  | F  |   |                             |                                  |                                     |
|                       | Ch  | arles Myers  |   |  | Ch.43-   | - Da a am  |   |                             |                                  |                                     |
|                       |   | /ER IN U. S. ARMED FO  |   | SOCIAL SECURITY NO. 17.  | INFORMANT  | y Bacon  | Address                                     |                             | 0 0 W                            | - 1                                 |
| { T 00.               | No.   | (it yes, give war or doles of  | service)  | None   | Shirley Bacon  | ,Ellicot   | t City                                      | , Md                        |                                  |                                     |
|                       |   |  |   |  |  |  |   |                             |                                  |                                     |
|                       | 18. CAUSE OF DEA  | ATH [Enter only one cou  | se per line f   | or (a), (b), and (c).]   |  |  |   | IN                          | TERVAL BETW                      | EEN                                 |
|                       |   | TH WAS CAUSED BY:  |   |  | generalized  | dehvdra  | tion  | IN                          | TERVAL BETW<br>NSET AND DE       | EEN                                 |
|                       |   | TH WAS CAUSED BY:  |   | or (o), (b), and (c).] Colitis and   | generalized  | dehydra  | tion  | IN OI                       | TERVAL BETW<br>NSET AND DE       | EEN<br>ATH                          |
| 1                     | 571.1   | TH WAS CAUSED BY:<br>IMMEDIATE CAUSE (6)<br>DUE TO   |   |  | generalized  | dehydra  | tion  | IN OI                       | TERVAL BETW<br>NSET AND DE       | EEN<br>ATH                          |
| 1                     | PART I. DEA<br>571. 1<br>Conditions, if   | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Dony, which  |   |  | generalized  | dehydra  | tion  | IN                          | TERVAL BETW<br>NSET AND DE       | EEN<br>ATH                          |
|                       | PART I. DEA<br>571. Conditions, if a<br>gove rise to Imme<br>(o), stating the   | TH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Dry, which diote couse  |   |  | generalized  | dehydra  | tion  | IN                          | STERVAL BETW                     | EEN<br>ATH                          |
|                       | PART I. DEA<br>571. )<br>Conditions, if a<br>gove rise to Imme<br>(o), stating the<br>couse lost.   | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Ony, which diote couse underlying (c)  |   | Colitis and  |  |  |   | OI                          | NSET AND DE                      | ATH                                 |
|                       | PART I. DEA<br>571. )<br>Conditions, if a<br>gove rise to Imme<br>(o), stating the<br>couse lost.   | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Ony, which diote couse underlying (c)  |   |  |  |  |   | OI                          | 19. WAS                          | ATH                                 |
| CATION                | PART I. DEA<br>571. )<br>Conditions, if a<br>gove rise to Imme<br>(o), stating the<br>couse lost.   | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Ony, which diote cause underlying HER SIGNIFICANT CON  USE WAS NATRIBUTING   | DITIONS <u>CO</u>   | Colitis and  | NOT RELATED TO THE TERM  | MINALDISEASE CO  | NDITION GIV                                 | OI                          | 19. WAS                          | AUTOPSY<br>DRMED?                   |
| CERTIFICATION         | PART I. DEA  571.  Conditions, if of gove rise to Imme (o), stoting the couse lost.  PART II. OT  | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO DRY, which diote cause underlying HER SIGNIFICANT CON  USE WAS NITRIBUTING 20  | DITIONS <u>CO</u>   | NTRIBUTING TO DEATH 8UT  HOW INJURY OCCURRED.  NJURY OCCURRED 20e. PI  | NOT RELATED TO THE TERM  | AINALDISEASE CO  | NDITION GIV                                 | OI                          | 19. WAS                          | AUTOPSY<br>DRMED?                   |
| MEDICAL CERTIFICATION | PART I. DEA  571.  Conditions, if or gove rise to Imme (o), stoting the couse lost.  PART II. OT  20a. EXTERNAL CA PRIMARY   or CC CAUSE OF DEATH  20c. TIME OF INJU- Hour o. m. p. m.  21. I certify t   | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Ony, which diote cause underlying HER SIGNIFICANT CON  USE WAS INTRIBUTING   IRY Month, Day, Year  19  | DITIONS CO b. DESCRIBE or 20d. It While of wor                      | NTRIBUTING TO DEATH 8UT  HOW INJURY OCCURRED.  NJURY OCCURRED 200. Pl  for the of work for the original property of the o | (Enter nature of injury in Po<br>ACE OF INJURY (Home, for<br>ctory, street, office bidg., etc.   | of I or Port II of it.  m, 20f. (City or h   | NDITION GIV                                 | (County)                    | 19. WAS PERFO YES X              | AUTOPSY DRMED? NO [                 |
| MEDICAL CERTIFICATION | PART I. DEA  571.  Conditions, if cogove rise to imme (o), stoting the couse lost.  PART II. OT  200. EXTERNAL CAPRIMARY   or CCAUSE OF DEATH 20c. TIME OF INJU- Hour o. m., p. m.  21. 1 certify to death resulted   | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  DUE TO  Dry, which diote cause underlying  HER SIGNIFICANT CON  USE WAS NITRIBUTING 20  19  hat I taak charge  | DITIONS CO b. DESCRIBE or 20d. It While of wor                      | NTRIBUTING TO DEATH 8UT  HOW INJURY OCCURRED.  NJURY OCCURRED 200. Pl  for the of work for the original property of the o | (Enter nature of injury in Po<br>ACE OF INJURY (Home, for<br>ctory, street, office bldg., etc.   | m, 20f. (City or h   | NDITION GIVen 18.)  awn)  actian            | (County)                    | 19. WAS PERFO                    | AUTOPSY DRMED? NO [                 |
| MEDICAL CERTIFICATION | PART I. DEA  571.  Conditions, if or gove rise to Imme (o), stoting the couse lost.  PART II. OT  20a. EXTERNAL CA PRIMARY   or CC CAUSE OF DEATH  20c. TIME OF INJU- Hour o. m. p. m.  21. I certify t   | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  DUE TO  Dry, which diote cause underlying  HER SIGNIFICANT CON  USE WAS NITRIBUTING 20  19  hat I taak charge  | DITIONS CO b. DESCRIBE or 20d. It While of wor                      | NTRIBUTING TO DEATH 8UT  HOW INJURY OCCURRED.  NJURY OCCURRED 200. Pl  for the of work for the original property of the o | (Enter nature of injury in Po<br>ACE OF INJURY (Home, for<br>ctory, street, office bldg., etc<br>ove, held an Autap<br>sicide, Homicid<br>M.D. CHIEF MEDICAL E                                       | m, 20f. (City or h   | NDITION GIVen 18.)  awn)  actian            | (County)                    | 19. WAS PERFO                    | AUTOPSY PRMED? NO (State)           |
| MEDICAL CERTIFICATION | PART I. DEA  571.  Conditions, if or gove rise to Imme (o), stoting the couse lost.  PART II. OT  200. EXTERNAL CA PRIMARY OF CC CAUSE OF DEATH  20c. TIME OF INJU- Hour o. m. p. m.  21. 1 certify the death resulted  ACTUAL  | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  DUE TO  DONY, which diote cause of the caus | DITIONS CO b. DESCRIBE  T 20d. It While of wor of the r causes      | NTRIBUTING TO DEATH 8UT  HOW INJURY OCCURRED.  NJURY OCCURRED 200. Pl for collection of work collections and collections are collected and collections and collections are collected and collected and collected and collected are collected and collected and collected and collected and collected are collected and c | (Enter nature of injury in Po<br>ACE OF INJURY (Home, for<br>ctory, street, office bldg., etc<br>ove, held an Autap<br>sicide, Homicid<br>M.D. CHIEF MEDICAL E                                       | m, 20f. (City or h   | NDITION GIVen 18.)  awn)  actian            | (County)                    | 19. WAS PERFO                    | AUTOPSY PRMED? NO (State)           |
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| MEDICAL CERTIFICATION | PART 1. DEA  571.  Conditions, if or gove rise to Imme (o), stoting the couse lost.  PART II. OT  20a. EXTERNAL CA PRIMARY   or CC CAUSE OF DEATH  20c. TIME OF INJU- Hour o. m. p. m.  21. I certify the death resulted  ACTUAL SIGNATURE  EXAMINER'S NAME (Type)          | ATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Dry, which diote couse underlying DUE TO LETO DUE TO DUE TO DUE TO LETO LETO LETO LETO LETO LETO LETO LE   | DITIONS CO b. DESCRIBE  T 20d. It While of wor of the r causes  Fis | NTRIBUTING TO DEATH 8UT  HOW INJURY OCCURRED.  NJURY OCCURRED 200. Proceed of the of work of the other of the | (Enter nature of injury in Po<br>ACE OF INJURY (Home, for<br>ctory, street, office bldg., etc<br>ove, held an Autap-<br>picide, Homicid<br>M.D. CHIEF MEDICAL &<br>ASSISTANT MEDIC<br>DEPUTY MEDICAL | m, 20f. (City or h  20f. (City or h  20f. Under  EXAMINER  EXAMINER  22d. LOCATION | em 18.)  ectian, termined c                 | (County)  Inquiry [cause ]. | 19. WAS PERFO YES \$\frac{1}{21} | AUTOPSY PRMED? NO (State) find that |

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